G1 and 37% G2, already malnourished, and in 96% G3 pts. In G1, all QoL scores improved ($p \leq 0.001$) proportionally to increased energy/protein intake ($p<0.003$), yet pain/discomfort worsened in association with anorexia ($p=0.07$) and dysphagia/odynophagia ($p=0.05$). In G2, all function scores improved ($p<0.03$); pain/discomfort worsened in association with anorexia ($p<0.001$) and dysphagia/odynophagia ($p=0.008$). All QoL scores worsened in G3. At 3-months follow-up nutritional status was maintained/improved in 88% G1, good QoL was reported by all G1 pts. Only 59% G2 and 31% G3 maintained nutritional status, whilst overall QoL deteriorated in G2 ($p=0.05$) and G3 ($p=0.001$).

Conclusions: During RT individualised counselling and supplements improved nutritional status and QoL. In the medium term, patient outcomes were only consistently improved by individualised nutrition education and adherence to adequate diets.

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Psychological and social aspects of survival of childhood cancer

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Objectives: The purpose of the study is to investigate the psychological and social aspects of survival of childhood cancer. More specifically, we examine if survivors are characterized by an increased tendency for anxiety, reduced sociality but also, we explore their personal views about the impact disease has had on their life.

Methods: 95 survivors (40 adolescents and 55 young adults) were examined. A sample of 100 young people was used as control. a) The Spielberger questionnaire was used for assessing anxiety. It is constructed by two subscales, the first (State) referring to anxiety as presenting condition and the second (Trait) referring to anxiety as personality trait. b) The standardized SF-36 quality of life scale was administered. This is a 36-item short-form. In the present study, we measured the scale of social functioning, which refers to the limitations in social activities because of physical or emotional problems. c) A semi-structured questionnaire was also administered where these young people focus on the differences, which possibly exist between them and other people of the same age. The survivors, also, analyze the way in which cancer has influenced their life.

Results: Anxiety is present in a significant percentage of this population. The mean scores for both subscales are higher in survivors ($p< 0,05$), especially in Trait, which is more representative of anxious personality. In terms of sociality, there is not any statistically significant difference between the two samples. On the contrary, survivors show more interest and compassion for others' problems. They are popular and have greater expectations from their relationships. Survivors feel they are different from other people of the same age, sometimes in a positive way. They may feel they are more vulnerable physically, but they believe they are more mature and. Additionally, they feel that disease has changed their attitude on life and their goals.

Conclusion: The experience of cancer in childhood changes the whole life of survivors, influencing the process of their maturation. Even if they do not exist major differences in physical ability, survivors express greater stress and many worries for their future health. On the contrary, they also attribute some positive outcomes to the experience of the disease, such as their early maturation, their greater interest for other people and their ability to fight for their goals.

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Impact of the nutritional status in geriatric oncology

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Background: The management of elderly cancer patients requires a multidimensional assessment to detect and to quantify medical and non-medical conditions which can interfere with cancer and its treatment. We have developed a minimal comprehensive geriatric assessment (mini-CGA) to prospectively evaluate the global health status of elderly cancer patients who are treated at our Cancer Centre. We present our data on one of the most important aspect of this assessment: the nutritional status of this very particular population.

Patients and methods: During the mini-CGA, patients met a dietician who assessed their nutritional status. Collected data included weight loss (bwl) during the last 3 months, caloric and protein intake, Mini Nutritional Assessment (MNA® Nestlé). In addition, we collected informations concerning their social and lifestyle status, their functional status (Activities of Daily Living and Instrumental Activities of Daily Living; ADL and IADL score), and comorbidity (CIRS-G). Pearson's χ^2 test was used to examine relationship between MNA and qualitative values. Survival time was defined as the time from the mini-CGA to the date of death or last follow-up. A Cox proportional hazards regression model was used to estimate the hazards ratio (HR) and 95 percent confidence intervals (95%CI) for significant risk factors of death with regard to malnutrition and others parameters.

Results: One hundred nineteen pts (64% male, 55% hospitalised) were evaluated from 05/99 to 07/01. Median age was 78 years (range: 66-92). Major tumour sites were prostate (55%) and breast (44%). Ninety-six pts (90%) had progressive disease, and 49 (41%) had metastatic evolution. Forty-six pts (42%) were fully independent in ADL (score=6), but only 13 pts (12%) in IADL (score=14). Fifty-seven pts (55%) had mild to severe disability/morbidity status (CIRS-G severity index $\geq$ 2). Only 31% pts were estimated well nourished (MNA >23.5), the body weight loss was $\geq$ 5% in 40% pts. A good nutritional status (MNA >23.5) was significantly associated with functional independence in ADL*, and absence of metastases** (* $p<0.001$,** $p<0.05$). Median survival time was 7 months (95%CI 5-9 months). In univariate analysis, metastatic status, MNA, ADL score and CIRS-G severity index were significantly correlated with overall survival (OS). In multivariate analysis, MNA<23.5 (HR=4.1, 95% CI: 2.2-7.8), CIRS-G severity index $\geq$ 2 (HR=2.5, 95%CI: 1.5-4.2) and ADL score <6 (HR=2.3, 95%CI: 1.3-3.9), were found to be independent prognostic factors for shorter OS.

Conclusion: These data show that nutritional status, ADL dependence and co-morbidity should interfere with survival independently of cancer status. Thus, these parameters must be taken into account for treatment decision making.

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Massage and aromatherapy massage for symptom relief in patients with cancer: a Cochrane systematic review

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Background: Aromatherapy massage is reported as the most commonly used complementary therapy in the health service and is employed in cancer and palliative care largely to improve patients' quality of life and reduce psychological distress. The aim of the systematic review is to investigate whether aromatherapy and/or massage decreases psychological morbidity, lessens symptom distress and/or improves the quality of life in patients with a diagnosis of cancer in the short and/or long term.

Methods: A comprehensive search strategy has been developed for identification of relevant studies, utilising databases including; The Cochrane Controlled Trials Register, Database of the Cochrane Complementary Medicine Field, MEDLINE, CINAHL, British Nursing Index, EMBASE, AMED, PsycINFO, SIGLE, CancerLit, Dissertation Abstracts International. Experts in the field of complementary therapies are being contacted and a hand search of relevant journals undertaken.

Results: 1322 references were retrieved from the searches. Two reviewers independently screened the references, excluding 1310, including 9 and no decision being possible on 3 due to lack of available information. The 9 included references represented 7 studies, all of which were randomised controlled trials. Analysis of the evidence presented by these trials is underway.

Conclusions: Despite a plethora of anecdotal evidence and case study reports supporting the use of aromatherapy and massage in cancer care, this review has identified 7 studies of massage and aromatherapy massage in patients with cancer that stand up to rigorous methodological scrutiny. The included studies will be presented and discussed.